

**WINDOWS OF OPPORTUNITY COUNSELING CLIENT INFORMATION FORM**

*CLIENT INFORMATION*

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
  
Primary Care Physician: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
  
Marital Status: **(please circle)**  
Single Married Divorced Widowed Partnered  
Parent/guardian's name and  
address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_

Phone Numbers  
Home: \_\_\_\_\_  
Work: \_\_\_\_\_  
Cell: \_\_\_\_\_  
  
Best way to contact: (circle)  
**Home Work Cell Email**  
  
**E-mail address:** \_\_\_\_\_  
  
Referral source: \_\_\_\_\_  
Initial to give permission to contact referral  
source: \_\_\_\_\_  
  
Names and Ages of Children: \_\_\_\_\_  
\_\_\_\_\_  
  
EMERGENCY CONTACT NAME & PHONE:  
\_\_\_\_\_  
\_\_\_\_\_

*PAYMENT AGREEMENT*

I understand that I am responsible for paying all charges in full at the time of services. **Payment is due at the beginning of your session.** (See therapist contract for rates.)  
  
Please make payment to Windows of Opportunity Counseling Services or Evelyn Schmechtig-Cochran, MFT.  
  
Signed: \_\_\_\_\_  
Dated: \_\_\_\_\_

Please note, we do not deal with or directly bill insurances. However, we can provide a receipt or statement upon request so that you can obtain reimbursement from your insurance or flex spending account.

*CANCELLATION POLICY*

We have a 24-hour cancellation policy for non-emergency cancellations. There is a fee for late cancellations or no-shows (see therapist contract). Thank you for your consideration.  
  
Initial: \_\_\_\_\_